PATIENT INFORMATION

Name: Last_____ First: _____

Address: _____
Street APT# City State Zip code

Birth date: _____ Age_____ Sex: Male ( ) Female ( )

Marital status: ( ) Married, ( ) Single, ( ) Divorced, ( ) Widowed

Social Security Number: _____-_____-_____ Home #:_____

Work #:_____ Cellphone #: _____

Email: _____

Occupation: _____ ( ) Full time, ( ) Part time, ( ) Unemployed

Employer's name and address: _____

Who refer you to our office? _____ Relationship: _____

In case of emergency, please contact: Name_____ Relationship: _____

Phone number _____

Insurance Information:
Do you have insurance? ( ) Yes ( ) NO

Insurance company's name: _____ Address: _____

Insured name: _____ Insured ID #_____

Group #_____

Patient relationship to insured: ( ) Self, ( ) Spouse, ( ) Child, ( ) Other_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits for Dr. Sim for services rendered by her in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHROIZE Dr. Sim to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Patient/guardian signature_____ Date: _____